WYOMING LEGISLATIVE SERVICE OFFICE

Memorandum

DATE April 7, 2023

TO Joint Labor, Health and Social Services Committee

FROM Anna Johnson, Staff Attorney

SUBJECT Prior Authorization Fact Sheet

Introduction

Prior authorization is a process through which health care providers obtain advance approval from health insurance providers, such as Medicaid or private health insurance, before a specific medical service is provided to a patient.

Wyoming is the only state that does not have a statute regarding prior authorizations. Without clear statutory guidance on the prior authorization process, the process itself can be inefficient and confusing. The six states below recently passed legislation or have legislation pending to make the prior authorization process simpler for health care providers and more efficient for providers and patients. These states have addressed various issues such as revocations of prior authorizations that have previously been approved, the creation of standardized prior authorization submission forms, timelines for which prior authorization requests must be determined and requiring that prior authorization request instructions are conspicuously posted online, easy to understand and are allowed to be submitted electronically.

As a caveat, this fact sheet is not a complete summation of the following states' prior authorization statutes. Many of these states have existing statutes regarding prior authorization that do not go directly to simplicity or efficiency of the process.

Iowa

- Iowa law prohibits the revocation or limitation of a previously approved prior authorization after the health care provider provides a health care service to a person per the prior authorization, subject to certain exceptions, such as waste, fraud or abuse.[1]
- Prior authorizations remain valid for not less than ninety days.[2]

[1] Iowa Code § 514F.8(2.).
[2] Iowa Code § 514F.8(3.).

Louisiana

- Every health insurance issuer authorized to do business in Louisiana must implement and maintain a program that allows for certain healthcare providers to submit to reduced prior authorization requirements in order to lessen unnecessary burdens for health insurance issuers and healthcare providers.[3]
- All Medicaid managed care organizations and health insurance issuers must utilize a single uniform prescription drug prior authorization form that does not exceed two pages. The Louisiana Department of Insurance is authorized to assess sanctions against any Medicaid managed care organization or health insurance issuer who does not utilize this uniform prior authorization form.[4]
- Prior authorization requirements must be furnished to a health care provider within twenty-four hours of a request for the requirements or posted in an easily searchable format online.[5]
- If a prior authorization request is denied, written notice of the denial must be given to the provider requesting the prior authorization within three business days of making the decision.[6]

Michigan

- Health insurers must provide a process for prior authorization requests to be handled electronically.[7] The prior authorization requirements must be described in detail and easy to understand.[8] The prior authorization requirements and a list of all benefits that are subject to the requirements must be posted conspicuously online.[9] Any changes to the requirements must be posted online before they are implemented.[10]
- Denials of prior authorizations must be made by a licensed physician, or by a physician or pharmacist if the prior authorization is for a prescription drug.[11]
- A prior authorization request that is not deemed urgent will be considered granted if the insurer fails to notify the health care provider of a decision within nine days of submission of the prior authorization request.[12]
- A prior authorization that is deemed urgent will be considered granted if the insurer does not notify the health care provider of a decision within seventy-two hours of submission of the prior authorization request.[13]

New Jersey

[3] La. Rev. Stat. Ann. § 22:1020.61.
[4] La. Rev. Stat. Ann. §§ 46:460.33; 22:1006.1.
[5] La. Rev. Stat. Ann. § 46:460.74.
[6] La. Rev. Stat. Ann. § 46:460.74.
[7] Mich. Comp. Laws § 500.2212e(1).
[8] Mich. Comp. Laws § 500.2212e(1).
[9] Mich. Comp. Laws § 500.2212e(2).
[10] Mich. Comp. Laws § 500.2212e(3).
[11] Mich. Comp. Laws § 500.2212e(5).
[12] Mich. Comp. Laws § 500.2212e(10).
[13] Mich. Comp. Laws § 500.2212e(11).

The legislation described below was considered during New Jersey's 2022 legislative session but has not been enacted. [14]

- Provides a definition of "medically necessary":
    - "Medically necessary health care services" means health care services that a prudent physician would provide to a covered person for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
        - In accordance with generally accepted standards of medical practice;
        - Clinically appropriate in terms of type, frequency, extent, site and duration; and
        - Not primarily for the economic benefit of the health benefits plan and purchaser of a plan or for the convenience of the covered person, treating physician or other health care provider.
- Current prior authorization requirements must be posted online and be readily accessible and easy to understand. If new requirements are developed, they cannot be implemented until the requirements have been updated online.
- All prior authorization denials must be made by a physician licensed in New Jersey who has knowledge of the medical condition or disease and has experience treating that medical condition or disease. All appeals must also be reviewed by a New Jersey physician.
- Health care providers must be notified within one calendar day of a prior authorization denial.
- A prior authorization for an urgent health care service must be determined within twenty-four hours of receiving all information needed to make the determination.
- If a health care provider certifies that a person requires emergency health care services within seventy-two hours of a person being admitted to the hospital, that will create a presumption that the services are medically necessary absent certain circumstances.
- If a person receives treatment for a chronic or long-term condition, one prior authorization for the treatment is sufficient.

<u>New Mexico</u>

- Health insurers are required to use a standardized form for prior authorizations for medical care, pharmaceutical benefits and related benefits.[15] An electronic portal must also be available for the submission of prior authorization requests.[16]
- If a prior authorization request isn't determined within seven days, it is considered granted.[17]
- Appeals of denied prior authorizations may be transmitted electronically.[18]
- Health insurers that do not comply with prior authorization requirements are given two warnings and then may be fined up to five thousand dollars for noncompliance.[19]

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[14] 2022 N.J. Laws AB 1255.
[15] N.M. Stat. Ann. § 59A-22B-5(A)(1).
[16] N.M. Stat. Ann. § 59A-22B-5(A)(2).
[17] N.M. Stat. Ann. § 59A-22B-5(B).
[18] N.M. Stat. Ann. § 59A-22B-5(F).
[19] N.M. Stat. Ann. § 59A-22B-4(C).

Texas

- If a physician or health care provider has had 90% of their prior authorization requests approved during the previous six months for a particular health care service, health insurers may choose not to require that physician or health care provider to request further prior authorizations for that particular health care service.[20]
- Prior authorization forms for prescription drugs shall be a single, standard form across all insurance issuers.[21] The Insurance Commissioner shall establish penalties for failure to accept the form or acknowledge its receipt.[22]
- Requirements for prior authorizations shall be posted online and be easily accessible and understandable.[23] Insurance issuers who fail to comply with prior authorization requirements must provide an expedited appeal for the health care provider.[24]
- If a patient is hospitalized, a prior authorization request must be determined within one business day after receiving the request or within one hour if the request is related to post stabilization care or a life-threatening condition.[25]

[20] Tex. Ins. Code Ann. § 4201.653.
[21] Tex. Ins. Code Ann. § 1369.304.
[22] Tex. Ins. Code Ann. § 1369.304.
[23] Tex. Ins. Code Ann. § 843.3481.
[24] Tex. Ins. Code Ann. § 843.3483.
[25] Tex. Gov't Code Ann. § 533.002821.